

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042511

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5940

FILED DEC 10 1962

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3817 BALTIMORE AVENUE</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDMUND LLEWELLYN BUCHANAN</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 23, 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-31-84</b>
9. AGE (last birthday) <b>78 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER - INDUSTRIAL CIVIL SERVICE</b>		11. BIRTHPLACE (City and state or country) <b>WASHINGTON, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>EDMUND KEY BUCHANAN</b>	
13b. MOTHER'S MAIDEN NAME <b>MARIE A. LEE</b>		14. NAME OF HUSBAND OR WIFE <b>RUTH BUCHANAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>VA HOSPITAL OFFICIAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral vascular accident; old myocardial infarctions</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Oct 4, 1962</b> to <b>Nov 23, 1962</b> and last saw him/her on <b>11-23-62</b> Death occurred at <b>4:40</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>ROBERT W. BROWN</b> (M.D.) <i>[Signature]</i>	
22b. ADDRESS <b>VA HOSPITAL, KANSAS CITY, MO</b>		22c. DATE SIGNED <b>11-23-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>NOV. 26, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <b>11-26-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Robert J. Frost*

Licensed Embalmer No.

4096

P. O. Address

K. C. Frost

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.